Surgical Clerkship Survival Guide

Clerkship Directors

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"In this harbor weary, sea-worn ships drop anchor
and new-launched vessels start their outward trips
Within these walls, life begins and ends."

-Words on the great seal at the entrance to Charity Hospital, New Orleans

Contents

Please Note: This manual is being updated. Any information in here is subject to change.

The information contained within this document is not comprehensive. If you have questions, please ask.

There will be site specific or specialty specific information that you will receive separately.

Overview – For Students at All Campuses

Goals

- Provide exposure to common surgical problems
- Help develop basic clinical decision-making skills
- Teach technical skills appropriate to third-year students
- Provide students an experience that allows them to evaluate surgery as a future career choice

Learning Objectives

1. Upon completion of the surgery clerkship, all students are expected to have seen patients with the following conditions:
    a. Abdominal pain/Acute abdomen
    b. Biliary Tract Disease (Gall Bladder & Bile Duct Disease)
    c. Breast Mass (not required)
    d. Colon-Benign-Diverticulitis, IBD, Malignant – Colon Cancer
    e. Hernias-Groin & Ventral, use of mesh
    f. Hemorrhage
    g. Post-Operative Care
    h. Surgical Critical Care
    i. Vascular Disease or Injury – arterial or venous
2. Upon completion of the surgery clerkship, all medical students will have performed:
    a. Vascular Examination ***and/or*** Breast Examination * currently not mandatory but encouraged
    b. Abdominal Examination
    c. Airway Assessment
3. Upon completion of the surgery clerkship, all medical students should be able to:
    a. Recognize common surgical problems and construct appropriate diagnostic management and referral algorithms for each condition
    b. Recognize the most common surgical emergencies that require urgent surgical consultation
    c. Apply the principles of resuscitation to a patient in shock
    d. Demonstrate professional attitudes and values towards colleagues and patients
    e. Perform as an effective member of a surgical team at a third year student level
    f. Elicit and present a history and physical exam in a format appropriate for surgical patients
    g. Recognize how their decisions and behaviors affect the quality of patient care and their professional environment while working in the OR, Clinic, and Floor
    h. Perform an OR Timeout to enhance quality of patient care, safety, and cohesiveness among interdisciplinary teams
    i. Consult and implement recommendations and information from colleagues when appropriate

Curriculum

The surgical clerkship is a nine-week long course during which students will spend six weeks in General Surgery and three weeks in a surgical subspecialty. Students in New Orleans for the General Surgery sub-

rotation will spend three weeks on Trauma Service and three weeks on one of the following services: Surg. Onc., Bariatric, Colorectal, or Cohn's.

The surgical curriculum will be taught by a combination of didactic and clinical teaching. However, the greatest opportunities for learning surgery will take place in the operating room, the clinic, and at the bedside. We strongly encourage you to consider these clinical activities a priority. Important learning opportunities include morning rounds, Mortality and Morbidity Conference, Surgery Grand Rounds, and Cohn's Conference. There are also many rotation-specific conferences for which you should obtain a schedule from the chief at the beginning of each rotation. The curriculum details are summarized by individual rotations later in this manual.

Surgery Clerkship (NOLA)		
General Surgery		**Subspecialty**
(Trauma) Trauma Team (Red) Trauma Team (Black) East Jefferson	(Gen Surg) Cohn's Colorectal Surg. Onc. Bariatrics	Cardiothoracic, ENT, ENT Peds, Neurosurgery, Pediatric, Plastics, Urology, Vascular, etc.
3 weeks	3 weeks	3 weeks

Assessment

Final grades will be calculated as follows:

Final Grade Percentage Breakdown

General Surgery Evaluation	30%
Subspecialty Evaluation	20%
Shelf Exam	25%
Suture Skills Lab	10%
Online Modules: Ethics & Nutrition	10%
Professionalism	5%
Total	100%

Your General Surgery Evaluation, Subspecialty Evaluation and Shelf Exam are broken down into 3 categories: Honors = 3pts, High Pass = 2pts, and Pass = 1pt. Each category is given a point value, which equates to the percentage for its corresponding area of evaluation. For example: If an Honors is given for an evaluation in General Surgery = the student receives 3/3 = 100% of 30%; if a High Pass is given for an evaluation in General Surgery = the student receives 2/3 = 66% of 30%; if a Pass is given for an evaluation in General Surgery = the student receives 1/3 = 33% of 30%. This criteria is the same for the Subspecialty Evaluation and the Shelf Exam score.

Your Shelf Exam score is determined by the national recommendation for the minimum passing score as directed by the Hofstee Compromised Recommended Passing Score in accordance with the NBME surgery examination grading guidelines. The current minimum passing score is 61 (updated October 2021). Please see the breakdown of how the Shelf Exam score is determined below:

Grade	Exam Score Criteria	Points Earned
Honors	**78 and above**	**3**
High Pass	**71 -78**	**2**
Pass	**61 - 70**	**1**
Fail	**60 and below**	**0**

As the minimum score is updated by the national recommendation, the grading scale will change to reflect the national standard for all grading categories: Honors, High Pass, Pass, and Fail.

Students will be evaluated by faculty and residents with whom they have had sufficient contact to allow a valid assessment. Student performance in the clerkship is directly related to the level of participation and enthusiasm shown for clinical responsibilities. Do not be afraid to ask questions or request guidance in identifying useful resources. In addition, please ask the chief resident to provide you with feedback at least once during each rotation.

Evaluations

All evaluation requests are submitted through New Innovations.

Minimum requirements

- One evaluation from a General Surgery faculty member (i.e., Bariatric, Colorectal, Surg. Onc., or Cohn's)
- One evaluation from a Subspecialty faculty member

Additional Guidelines

- While students undergoing their subspecialty rotation will be free to choose their attending, those undergoing the General Surgery Rotation will have preselected attendings.
- You are not required to submit an evaluation from Trauma Service.
- In addition to the required two evaluations, you may request evaluations from residents and faculty, though **you cannot exceed more than three evaluations per sub-rotation**.
- Select the evaluation questionnaire on New Innovations carefully (general surgery form vs. subspecialty evaluation form)
- You **must** request your evaluation before the last day of the clerkship. ***If you wait until after the last day, you will not be able to access the clerkship in New Innovations.***
- Please do not send an evaluation twice. If the evaluation is not completed after two weeks,

please contact the attending, to complete your evaluation, or contact the coordinator.

- Remember, ***you have two weeks after your evaluation has been completed to speak to your resident or attending about any evaluation concerns.*** After the two-week period, evaluations cannot be re-opened and **NO** grade changes will be made.

Helpful Insights

- All evaluations submitted will be used to determine your final score. Therefore, you should request extra evaluations thoughtfully and cautiously. It is not uncommon for residents to grade tougher than attendings.

Shelf Exam

The shelf exam is worth 25% of students' final grade. For Test Content, please see the separate e-mail and the NBME website. (Link below)

https://www.nbme.org/subject-exams/clinical-science/surgery

Suture Skills Lab

A portion of the final grade (10%) will be calculated from successful completion of the Suture Skills Lab.

- Students will be given a numbered Suture Skills kit that includes:
  - A knot tying board
  - A suturing kit
- Students **MUST** return the Suture Skills kit (knot tying board and suturing kit) to your branch coordinator. **If the kit is not returned, a grade of an *Incomplete* will be given in the course until the kit is returned.**
  - If the kit is returned with any trash and/or used needles, there will be a loss of the Student's Professionalism Grade.
- Throughout the 12 week Clerkship, students are required to view demonstration videos on the Clerkship website and practice to proficiency.
- If you are doing your suture skills in Baton Rouge or Lafayette, please forward a copy of your certificate/test to the Surgery Clerkship Coordinator so that you will receive credit for taking the suture test.

The types of knots included in the Suture Skills Lab are:

1. 2 handed knot – surgeon
2. 2 handed knot –slip
3. 1 handed knot – slip
4. Simple suture w/ instrument tie
5. Vertical mattress w/ instrument tie
6. Horizontal mattress w/ instrument tie

The Suture Skills Lab grade will be calculated according to completion of Suture test and the return of the suture kit in the condition it was assigned to you.

Online Modules: Ethics and Nutrition

Faculty and residents expect you to be familiar with these concepts as you care for your patients.

- Both modules are completed online: **Nutrition Module** and **Ethics Module**
- Make sure you take the quizzes after each module
- See 3rd and 4th Year Student Resources for additional information

Mid Rotation Feedback Form

Students are required to get feedback from faculty or a resident at the midway point during their General Surgery rotation. This form is an LCME requirement and must be submitted to the Clerkship Coordinator—**no exceptions**. The mid-rotation evaluation form will be included in the General Surgery portion of your grade.

Core Clinical Activities — Purple Book

This is another LCME requirement that must be completed and submitted to the Clerkship Coordinator and will be a component of your General Surgery grade. You'll receive the booklet day one and must get each page signed by the end of the clerkship.

What's in the Purple Book?

Core Clinical Conditions	**Online Cases**
1. Abdominal Pain	Appendicitis
2. *Breast disease* not mandatory*	
3. Colon-Benign-Diverticulitis, IBD, Malignant – Colon Cancer	Carcinoma in the colon
4. Biliary Tract disease- Gall Bladder & Bile duct disease	Common bile duct obstruction
5. Hernias – Groin & Ventral, use of mesh	
6. Post-operative care including fluid management, Foley, advancement of diet, choice of and duration of antibiotic, NGT management, Drain management	
7. Surgical critical care	Spontaneous left pneumothorax
8. Vascular disease or injury – arterial or venous	Aortic dissection
9. Hemorrhage	Diverticulosis, Anemia
Observed Skills	
Abdominal Exam Vascular Exam* Airway Assessment Breast Exam* Progress Note Feedback	

**Breast disease, the breast exam, and the vascular exam are currently not a mandatory experience for students on Surgery- We anticipate most students will have exposure to some breast disease and vascular exams but understand this may not be possible. Until we can resolve some logistical issues, we cannot guarantee this experience on General Surgery for all students.*

Helpful Hints

- The observed skills and note feedback pages **must be signed by a Faculty Member**, while the remaining pages may be signed by residents.
- For the Airway Assessment, shadow an Anesthesiologist or cRNA and observe pre-surgery intubation. The Anesthesiologist or cRNA can sign the book.

Professionalism

Professionalism is worth 5% of your grade and will be based on your ability to complete your assigned tasks while following directions, abiding by deadlines, showing respect to coworkers, etc. Clerkship directors, attending physicians, residents, and the Clerkship Coordinator can all give input to help determine your professionalism score. **Make sure you respond to emails and submit all documents and assignments in a timely fashion. For ease of communication, it may be wise to create an e-mail signature, both on computer and mobile, that has all contact information.**

Feedback – Clerkship, Attendings, and Residents

We wish to make the surgery clerkship a worthwhile experience for you and are always striving to improve. Students should feel free to provide us with any feedback or suggestions at any time, but we do ask that students complete the following evaluations on New Innovations—

- Specific evaluations following each sub-rotation
- Evaluations of specific residents and faculty
- Evaluation of the clerkship as a whole

More importantly**, please contact us immediately if you experience problems with your rotation.**

Clerkship Evaluation Guidelines- Surgery (Updated Sept. 2022)

Descriptions of basic expectations for third year students are listed for each item in the domains **Personal Integrity, Work Habits, Professionalism, Fund of Knowledge, Written Skills, Oral Presentations, Suture Skills, and Self Education.** This is the exact transcript of the form that faculty/residents use to evaluate you. This is also an instruction manual on how to achieve an "Honors" on your clinical evaluation.

PERSONAL INTEGRITY

Does the student display honesty in presentation, write-ups, progress notes & all other clinical activities?

Pass/Fail

WORK HABITS

Fail: Poor attendance; shirks responsibilities; disorganized' unable to do assignments. Frequently late.

Pass: Attends required functions; assumes expected responsibilities; somewhat inefficient. Usually punctual**.**

High Pass: Occasionally attends extra functions; independent initiative; well organized.

PROFESSIONALISM

Fail: Disheveled, unclean or inappropriate appearance. Poor attitude, disrespectful to staff, patients, or colleagues

Pass: Acceptable appearance and behavior

High Pass: Appropriate attire and conduct, affable and interacts well with others

Honors: Displays innate leadership skills, sets the standard

FUND OF KNOWLEDGE

Fail: Cannot recall basic science and clinical information and relate it to cases.

Pass: Basic knowledge of disease processes and pathologic events; some ability to relate information to clinical material.

High Pass: Above average knowledge; able to correlate this knowledge consistently to clinical material.

Honors: PGY-1-level fund of knowledge or better with mature application to clinical setting.

WRITTEN SKILLS (Medical Records)

Fail: Poorly prepared (has irrelevant information or important data missing); few notes; often late; major problems omitted, or relies heavily on copy and paste.

Pass: Contains basic information; notes usually prompt; cover major problems but have minor omissions.

High Pass: Well done and organized; complete and relevant but no detailed analysis or differential of problems. Does not include irrelevant data

Honors: Outstanding notes- prompt, concise, thorough, relevant; important problems reported and adequately explained. Clearly synthesized relevant labs and diagnostic studies to describe the clinical picture

ORAL PRESENTATIONS (Case presentations and progress reports)

Fail: Disorganized and poorly integrated

Pass: Generally organized but verbose or incomplete. Relies heavily on written notes

High Pass: Organized and complete. Occasionally refers to written notes

Honors: Complete, concise, orderly and polished. Able to answer detailed questions without referring to written notes

SUTURE SKILLS

Fail: Shows no evidence of ever having practiced suturing or knot-tying

Pass: Difficulty performing task with fluidity. Able to demonstrate basic skills even if end result is not adequate or requires continuous coaching

High Pass: Uses proper technique, able to tie and suture with adequate result. Requires minimal coaching

Honors: Sutures and ties with ease and dexterity; PGY-1 level or better end result without any coaching

Not observed

SELF EDUCATION

Fail: Lacks adequate knowledge of own patients. Shows no evidence of ever reading anything on surgical disease

Pass: Displays basic textbook knowledge of own patients' disease or clinical conditions

High Pass: Has thorough knowledge of patient diseases and conditions.

Honors: Intellectually aggressive, demonstrates extensive supplemental reading; knows disease processes of other patients on service. Occasionally educates the team by bringing in scientific literature

Please rate the professional capacity of this student.

Insufficient Information

I would not recommend this student as a house officer.

I would be reluctant to recommend this student as a house officer.

I would recommend this student as a house officer.

I would strongly recommend this student as a house officer.

Final Grade

Final Grade

Fail

Pass

High-Pass

Honors

Formative Feedback (Specific suggestions/recommendations for improvement - not to be included in MSPE)*

Summative Evaluation Comments (To be included in MSPE)

Medical Student Duty Hours Policy

Duty Hour Regulations

The ACGME (Accreditation Council for Graduate Medical Education) mandated duty hour restrictions for all resident training programs effective July 2003. We ask that medical students respect the same rules. Problems with enforcing the rules must immediately be brought to the attention of the clerkship director or coordinator.

Duty hours are defined as all clinical and academic activities related to the rotation, i.e. patient care, administrative duties related to patient care, the provision for transfer of patient care, time spent in- house during call activities, and scheduled academic activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.

- Duty hours should be limited to 80 hours per week, averaged over a four-week period, inclusive of all in- house call activities.
- Students must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.
- Adequate time for rest and personal activities must be provided. This should consist of a 10hour time period provided between all daily duty periods and after in-house call. Students may occasionally choose not to do this to avail of a unique educational opportunity.

On-Call Hours

The objective of on-call activities is to provide students with continuity of patient care experiences throughout a 24-hour period. In-house call is defined as those duty hours beyond the normal workday when students are required to be immediately available in the assigned institution.

- In-house call must occur no more frequently than every third night, averaged over a four-week period.
- Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours.
- At-home call is defined as call taken from outside the assigned institution. The frequency of at home call is not subject to the every-third-night limitation. However, at-home call must not be so frequent as to preclude rest and reasonable personal time. If a student is called into the hospital from home, the hours spent in house are counted toward the 80-hour limit

Monitoring of Duty Hours

Currently, we do not have mandatory duty hours reporting for students. We ask that you keep a personal record and bring violations to the attention of the chief resident in the first instance. Please advise the clerkship coordinator of any difficulty encountered with this policy.

Medical Student Responsibilities – Overview

Floor Work

Following Patients:

- Patient: Know your patients. This includes reading about and understanding their medical conditions and surgeries. Furthermore, the medical student should know the active problems with

their patients (infections, post-op complications, etc.) along with pertinent labs, radiology, procedures being done, and why.

- Patient Load: The medical student should generally carry around 3 patients. The first day on service can be used to familiarize students with the work flow, presentation expectations, etc.; students should be feel a necessity to present on day one. After the first day on service, students should pick up 2-3 patients to follow and present on rounds.
- AM Rounding: Morning rounds take place between 5:00am and 6:30 am. Ask the intern or chief resident the night before to determine the exact time. You are responsible for presenting the patients you are following during rounds. The medical student should plan on arriving with ample time before morning rounds to see the patients, write down vitals and I/O's, and do a physical exam. The Surgery Progress Note should be filled out and used as the general format for presenting.
- PM Rounding: Afternoon rounds are variable in when they take place. Because the student is in clinic or the OR, he/she generally does not present in the afternoon. However, you should attend if you are out of surgery or the clinic before afternoon rounds begin. The attendings often round in the afternoon, and this is a good time to learn more about the management of the patients in the floor.

General Floor Duties:

- Assist the Intern: When you are not in surgery or if the clinician needs any help with floor duties, any help you offer can aid in the more efficient management of the patients on this busy service.
- Labs/Chart Notes: Following morning rounds and morning report, the medical student should put the morning labs for all the patients on their respective progress notes. Routine AM Labs are generally not available until after 0800 so it is imperative that you follow them up for your patient in the morning between other duties. Any abnormalities should be brought to the immediate attention of a resident
- Wounds & Dressings: All wounds need to be inspected daily. Wounds to be changed multiple times a day must be done as directed. It is the student's responsibility to confirm that this was done and assist whenever applicable. See separate section on Wound Care (Appendix 3)
- Abnormal Findings: Any abnormal findings on labs, radiology, vital signs, wound changes, or the patient's appearance must be brought to the attention of the resident or intern immediately.
- Ancillary Duties: Ask the intern about helping with dressing changes, staple removal, NG tube placement, JP drain removal, etc.

Helpful Hints for Morning Rounds

What to ask and record when interviewing patients on the floor:

- Is the patient having bowel movements/stoma output, and how much? Is the patient passing gas?
- What was the recorded urine output?
- What diet is the patient on? And of that diet, what has the patient actually eaten/drank that day? Was there any nausea/vomiting?
- Is the patient's pain adequately controlled, and what type of pain management are they?
- Has the patient been getting out of their hospital bed and ambulating the halls?
- Is the patient using their incentive spirometer? What is the volume?
- Is the patient's Urine output adequate? (>.5ml/kg/hr)
- Does the patient have a Nasogastric Tube, and how much output is it producing?

- Are there any drains, and what is the output?
    - Always check the type of fluid in these bulbs.
        - Most patients have serous or serosanguinous drainage from their drains.
        - Bilious drainage would suggest a leak somewhere; so in a patient with a small bowel resection, this would suggest a leak from their anastomosis.
        - Other types of drainage suggesting a potential problem include stool, frank blood, etc.
- Any other medical issues overnight? (Fevers, Hyper/Hypotension, Tachycardia, Hyperglycemia, worsening condition, etc.)
- A very important aspect of the way the chiefs/attendings often think is related to what is keeping the patient in the hospital. Another way to think about this is to ask yourself if the patient has improved enough clinically, that their risk is low of going home and having a serious complication.

To go home, patients need to:

- Hydrate themselves orally - They need to be drinking well and often should be tolerating some regular food, but drinking fluids is most important.
- Have their pain controlled well with oral pills ○ Therefore, know if they are still dependent on the PCA or IV injections
- Be mobile ○ Are they walking?
- Be clinically stable - Normal vitals, off O2 (unless on home O2), no fevers

What to observe and elicit during the physical exam:

- Vascular Exam- Check pulses in any extremities with trauma or that have been re-vascularized. Any changes need to be brought to the attention of the resident ASAP
- Abdominal exam
    - **Shape**: Flat – Full – Distended
    - **Sensation**: Non-tender – Appropriately tender
        - focally tender – Generalized tenderness – Acute abdomen
    - **Nature: Soft – Firm – Tender – Rigid**
    - **Percussion**: Dull vs. Tympanic
- Bedside Dressing Changes/Wound Inspection
    - Carry gloves with you and be ready to help undress any wound during rounds. You should be the first one on the wound if the attending says they want to look at it.
    - Have gauze, tape, flushes, etc. A way to make a great impression is to squirrel away these supplies and have them in your pocket in case they are needed. Residents will appreciate the fact that it makes rounds faster, and it shows you have initiative and resourcefulness
- Ostomy/Incision Exam- ○ Examine the bandages first- Look for whether they are dry, intact, and whether there is any drainage or not.
    - Examine the incision sites- Look for drainage from the incisions along with erythema and pus. Increased drainage in the days/weeks following surgery may suggest wound dehiscence. Increased erythema and tenderness may suggest wound infection.
    - Examine the ostomy site- You can tell whether the person is passing gas based on whether the bag is inflated or not.

- Furthermore, you can assess whether the person is producing stool. Lastly, check for the same physical findings you did with the incision

Operating Room

- Patient- Know the patient. Look at OR schedule the day prior, and go see the patient that evening or the morning of the procedure. **Read the H&P.**
- Disease Process- Look up and know/understand the disease or condition, the etiology, work-up, prognosis, etc.
- Anatomy- Review pertinent anatomy (you're the last person in the room to have taken gross anatomy…you are the expert). You will be asked expert-level questions.
- Surgery- Understand what comprises the surgery being performed, indications, and alternatives.

Ancillary Duties

- Patient Transport- Always assist anesthesia with bringing the patient to the OR and back to PACU. This is another good time to meet the patient if you weren't able to the night before. You can also be the eyes and ears for the intern, alerting them when the patient is being moved, if any issues come up (incomplete consents, IV access issues, questions from anesthesia, etc.)
- General- You can also help with moving the patient from bed to OR table, grabbing warm blankets (ask nurse where to find these), cleaning after case, etc.
- Post Op Note- Pull the Post-Op note from the patients chart after the case has finished and fill it out. Ask the anesthesiologist for information such as IVF's, Urine Output, Estimated Blood Loss, etc.
- Laparoscopy Cases- Always go to the Laparoscopy cases because you will be controlling the camera which allows the attending and resident to work the case together.

Etiquette

- Introductions- **ALWAYS** introduce yourself to the scrub nurse and circulator. Offer to grab your gloves and gown. Ask them if you can be of assistance in any way. These people can make or break your OR experience so stay on their good side.
- The Instrument Table & Mayo stand- This is the scrub nurse's domain where he or she rules with absolute impunity. Touch them at your own peril! (Be prepared to lose a finger if you do so without asking permission.)
- Communication- Although tempting, withhold from asking the scrub or nurses for things even if you think you know it is needed. If you ask for an instrument, the scrub might be looking for it when the surgeon asks for something else…let the surgeon do all the talking. **You just listen.**
- Never ask to perform a procedure- Never ask for the scalpel, you will earn it. Your resident or staff will determine if you are ready.

Student Role

- Purpose- You are there to learn, but a student's need to learn does not supersede all other needs in the OR. Usually, it's an unwise decision to endlessly ask questions, or discuss blood supply to the colon when a stapler has misfired. Use judgment to ask questions at appropriate times.

Clinic

Etiquette

- Be the 1st to clinic. Avoid strolling in after a social breakfast in the cafeteria.
- Introduce yourself to the clinic nurses and offer your assistance. Make their job easier and they can make you look good.
- Pay attention to the process of filling out paperwork and preparing patients for surgery. Take the

initiative to get the process rolling if you see

- If clinic is extremely behind, use your judgment about questions, etc. (same idea as the OR).

Mechanics of Clinic

- H&P vs. SOAP note: An initial visit usually requires an H&P as does a pre-op visit.
    - Additionally, if a surgery is planned, bring a consent form (you can't consent the patient, but can make clinic flow smoother if you have the consent form 'handy'. Ask the resident or staff which form to use).
    - A post-op check or general f/u requires a brief SOAP note. The SOAPs are for dictation purposes so write them as such: dense in information, short in length. If you are unsure whether a visit requires a SOAP or H&P, ask the resident.

Student Role

- Be aggressive — this is not a "shadowing" opportunity; it's a chance to hone your H&P skills, efficiency, and presentations.
- Help clinics run efficiently and the chiefs, residents, and/or attending may have the time to teach.

General Surgery Sub-rotations — New Orleans

The General Surgery rotation in New Orleans, consists of a 3:3 format. Students will spend three weeks on either the Bariatric, Cohn's, Surg. Onc., or Colorectal Service and three weeks on Trauma or East Jefferson Gen Surgery. During their East Jefferson or Trauma rotations, they will each spend 2 weeknights and 1 weekend night on Trauma Call. Students on their 3 weeks of General Surgery rotation (Bariatric, Cohn's, Surg Onc, and Colorectal) will not take trauma call during those 3 weeks.

Didactics

M&M, Grand Rounds, & Cohn's Conferences — Thursdays, 7am-11am

M&M and Grand Rounds — Thursdays, 7am – 9am

Location: UMC, 1st Floor, Conference Room F

Cohn's Conference — Thursdays, 9am – 10:45am

Location: The Clerkship Coordinator will inform you of the location.

Conference Attendance, Sign-Ins, and Attire

Morbidity and Mortality (M&M) Conference and Grand Rounds are **required for all students** on General Surgery rotations and Subspecialty rotations, *except* for students on the following subspecialty rotations:

- Orthopedics
- ENT
- Urology
- Plastics
- Neurosurgery

Cohn's Conference is required for all Surgery Clerkship students—no exceptions!

If you will not be able to attend a conference, please send a message to the Clerkship Directors and Clerkship Coordinator *prior to* the missed conference. There are certain circumstances in which absence from Cohn's will be accepted. Reach out to the coordinator for questions.

Signing In

Signing in to M&Ms requires you to scan a QR code at the beginning of the M&M presentation. You will be given instruction to download the app that you will use to scan the QR code.

Attire

Students must wear clinic attire with white coats to all conferences. The only exception is a student who is actively on-call for the Trauma service.

Cohn's Conference Presentations

Weekly, at Cohn's Conference, 2-3 surgery clerkship students will each formally present a surgery patient. Students are invited to submit a copy of their presentation to the Clerkship Directors and cc the Clerkship Coordinator **by Monday** of the week they are presenting to receive feedback prior to presenting. It is easiest for students to bring their presentations on flash drives, but you must also submit it in PPT or PDF format to the Clerkship Coordinator.

Trauma

Black Team, Red Team = LSU Residents and Staff

White Team = Tulane Residents and Staff

Patients should be admitted to the team that is on call that day. Patients admitted on a Trauma Fellow call night are admitted to the pre-designated team on the schedule posted in the TICU lounge. We will make every effort to pair students on call with their trauma team, if they are on one, in order to help ensure continuity of care. Due to logistical issues, this may not be possible, but it is a goal.

GENERAL SCHEDULE (Subject to change)

1. Round on patient individually: every day, 0430 – 0700
2. Update the list: edit and add patient information on the team's list and print one for every team member (usually 6-7)
3. Pre-round with intern and chief resident: every day, sometime between 0600-0700
   - *Some chief residents will like to pre-round before sign-out and others won't. Just ask the intern or chief resident about this on your first day.*
4. Morning Sign-Out: everyday, 0700, UMC second floor conference room
5. Rounds with attending: every day, immediately after sign-out and variable length of time
6. Variable schedule: after rounds with the attending; you will do floor work, add-on surgery cases, and trauma activations if team is on call that day. Your intern will guide you and let you know what needs to be done that day.
7. Go home: you'll leave whenever everything is done for the day. Some days you'll go home in the early afternoon and other days you'll stay all day.

Other Responsibilities

1. Clinic, Monday afternoons

   All students on trauma attend. When the nurse brings back a red patient folder, an available student will take it and look up the patient's history in Epic. The student will then

go and see the patient individually to get an idea of why the patient is there that day and to do a brief physical exam (heart, lungs, abdomen). The student will then present the patient to an available resident or attending. The student and doctor will then go and see the patient together. Ask the doctor if you should write a note on the visit or if he/she wants to write it (everyone is different).

**Staple remover kits, suture removal kits, gauze, and tape will be on the front desk for quick access. Other material will be in the clean workroom, which is locked. Ask one of the nurses to let you in for these extra materials.*

Overnight Accommodations at UMC (Updated Sept. 2022)

UMC ID Badges

Regarding UMC badge pick up: The UMC Public Safety Office is located on the 2nd floor of the hospital, Room 2673 (above PJ's Coffee). Office hours are M-f, 8am-10am, and 2pm-4pm and are strictly enforced. Carla Jackson 504-702-2037 is UMC Public Safety contact.

Call Rooms

Student call rooms are not assigned. They are on a first come first serve basis.

UMC Med Student Call Rooms (Tower 3, Floor 5) Badge access only

Room #	code	LSU Med Student Call Rooms for Overnight Call
5356	531700	LSU - Med Student (Surgery)
5357	531700	LSU - Med Student (Medicine)

**Additional call rooms are available for use if all LSU student rooms are in use and you are taking overnight call. Dial the House Supervisor (see numbers below), explain your situation, and ask for a "hotel room".

- Housekeeping will service the rooms daily.
- Please note: If personal belongings are in the rooms, they will not enter; and the room won't be cleaned. Please use the lockers in the gender specific locker rooms for your personal belongings.
- Locker Rooms with private, bathrooms, showers and "spa" lockers available for use.
- Instructions for lockers are posted in the space. Each user must create their own locker code. Expectation is only to be used while assigned to UMC. If belongings are left behind while you are no longer assigned to UMC, Public Safety will remove your belongings from the LOCKER. Please report any non-working locks to LCMCAcademicAffairs@lcmchealth.org

If you ever need a call room, forgot your pin #, need a nap, or have any other issues, you can contact the UMC House Supervisors or UMC Security 24 hours a day and 7 days a week:

LCMCAcademicAffairs@lcmchealth.org
or
Dial 0 from any in house telephone

Subspecialty Rotation Information

Cardio-Thoracic Service

Learning Objectives

Upon completion of the cardio-thoracic surgery rotation all medical students should be able to:

1. Describe basic cardiovascular physiology including volume management and the management of congestive heart failure.
2. Discuss cardiac electrophysiology including the rudimentary aspects of pacemaker management, arrhythmia control, and anti-arrhythmic pharmacology.
3. Describe the basic management of ventilation and oxygenation in thoracic patients, including the management of supplemental oxygen, nasal CPAP, incentive spirometry, and respiratory therapy.
4. Describe the management steps during a cardiac arrest and near arrest.
5. Describe the basis of thoracic imaging, including CT scans of the chest and vasculature as well as the interpretation of chest x-rays.
6. Discuss the medical management of acute coronary ischemia and acute valvular heart disease.
7. Discuss the basics of the management of acute aortic emergencies.

After rotating in the Post-Operative ICU, medical students should be able to:

1. Describe the use of intra balloon pumps as well as other cardiac assist devices including ventricular assist devices, ECMO, and right ventricular assist devices.
2. Describe the management of cardiac arrest and near arrest with both closed techniques, pharmacological techniques, and open cardiac massage and resuscitation.
3. Describe the use of advanced measures to deal with problems of the pleural space including every form of thoracic drainage.
4. Describe the management of acute respiratory insufficiency including acute pulmonary disease, management of the airway, and bronchoscopy both for diagnosis and therapy.
5. Discuss the treatment of pleural space problems including pneumothoraces, hemothoraces, empyema, and malignant pleural effusions.
6. Develop an understanding of the pathophysiology of benign esophageal diseases such as achalasia, paraesophageal hernias, and gastroesophageal reflux disease, and the diagnostic studies that are used to evaluate patients as well as the surgical therapies.
7. Discuss the co-morbid conditions in patients undergoing thoracic operations and how to appropriately stratify their operative risk.
8. Discuss the interpretation of pulmonary function studies, x-rays, etc.

Planned Clerkship Experience

1. The resident will organize the student to prepare for the operation the student will participate in the next day. The student will then read up about the operation the night before and prepared to answer questions.
2. Students will report/present on rounds on every such patient post-operatively.
3. Students will go to Clinic.
4. The student will ask the faculty for Performance Evaluations as well as a resident if they wish. Each student must have at least one faculty evaluation and may solicit more than one faculty or

additional evaluations from residents. Faculty evaluations will result in at least 60% of the final evaluation grade.

5. The students will learn from the Cardiac Interns the protocols/techniques for pulling pacing wires, chest tubes, central lines, etc.

Responsibilities

Medical students should participate in all clinical patient and educational activities, both inpatient and outpatient, while on this rotation.

ENT Service (All Locations) (Updated Sept. 2022)

Goal

Provide third year medical students a meaningful and comprehensive introduction to the field of Otolaryngology-Head and Neck Surgery.

Third Year Otolaryngology Clerkship

The third year clerkship will emphasize mastery of a core fund of knowledge and application of that fund of knowledge in clinical practice – especially primary care. Students will participate fully in the everyday activities of a busy academic otolaryngology practice including inpatient rounds and consultations, emergency center encounters, operating room, faculty and LSU Health Clinics, and didactic sessions.

Settings

- Our Lady of the Lake Regional Medical Center- B.R.
- LSU Voice Center- B.R.
- OLOL Hearing and Balance Center- B.R.
- Center for Plastic and Reconstructive Surgery- B.R.
- University Medical Center- N.O.
- Children's Hospital- N.O.
- University Hospital & Clinics- Lafayette, LA

Text /Required Reading

Primary Care Otolaryngology Fourth Edition AAO-HNS 2019. Available as a free .pdf download22

Journal presentation

Student will select and present one original article related to the field of Otolaryngology.

Activities

- Morning rounds, data collection, patient documentation and presentations
- Didactic sessions (see below)
- Operating Room -active participation in a wide variety of surgical cases
- Journal article presentation
- Faculty clinics-work directly with attending staff and residents in the clinic setting
- LSU Health clinic-actively evaluate patients under resident and staff supervision
- Inpatient and EC consultations – active participation in the evaluation and management of these patients

Didactic Sessions

- Daily Q&A. Time will be set aside each day with attending staff for questions and for discussion of

important topics

- Wednesday lectures/tumor board weekly
- Monthly "Didactic Day". This daylong event is an excellent educational opportunity for students, residents and faculty. Time is set aside once per month for the entire department to convene for patient rounds, morbidity and mortality presentations, and lectures on key otolaryngology topics by residents, faculty and guest speakers

Clerkship Objectives

• Gain mastery of core otolaryngology fund of knowledge as outlined in required reading
• Perform an independent comprehensive history and physical and detailed head and neck examination
• Expand knowledge of fundamental surgical principles
• Learn diseases/conditions that require otolaryngology referral
• Acquire and improve basic surgical skills including hand washing, proper OR protocol/procedures, sterile gowning/gloving, basic suturing skills, knowledge of basic surgical instrumentation
• Acquire and improve effective communication skills with concise organized patient presentations
• Demonstrate effective documentation skills through written h&ps and progress notes. Use electronic health records and digital resource media effectively.
• Improve critical analysis. Effectively present an original article from the ENT literature.

ENT - Pediatrics (Children's)

Overview

This three-week experience will take place at Children's hospital. The surgery lounge and facilities are located on the second floor of the hospital. Enter through the doors closest to the railroad tracks and walk through the Concourse. Take the Drum elevator to the second floor. Exiting the elevator bay, turn left and you will see the Surgery Lounge. The Physician Workspace is inside the lounge. Be sure to text your resident in advance to not only let them know you are coming

You will need to acquire the Children's Hospital blue scrubs on your first day. Just go to the front desk of the surgical facility to register. Do not enter the surgical facility (OR lobby) without a bouffant cap on.

You will be lambasted if you neglect to do this. All the caps you could ever want, in addition to the masks and beard covers, are located conveniently right outside the lobby.

The list of surgeries occurring that day will be located on the giant monitors in the surgery lounge and inside the OR lobby. Your resident should tell you what attendings that you will be primarily working with. Unless otherwise stated, you do not need to bird dog cases. Observe the surgeries and be amazed at the intricacy.

Typical Day

1. Arrive at a time stated by your resident (probably around 6 am) and meet them where specified for rounds, which will likely just be you and your resident.
   a. Rounding with the attendings usually is a once-a-week occasion (likely Thursday), and most/all of the attendings will be present. This is a great opportunity for you to write a good, clean note and make a nice, crisp presentation. Agree with your resident on
2. After rounds, go to the OR and prepare for cases. Read up on the patient and why the procedure is being done. It is a good idea to do a full scrub at the beginning of the day as well.
   a. Most pediatric ENT procedures are not done sterile. There is simply no need to, as the

human mouth is a generally disgusting place to begin with.

b. For the occasional case that requires sterility, it is good to have fully scrubbed already at the beginning of the day. Ask your resident/attending if you need to scrub the case. The procedures in ENT are so intricate that there just often isn't a need for you to scrub…it is usually a 1-2 person job.

c. Take every opportunity to perform a procedure when asked if you would like to. There is no need to ask outright if you can do something. You will show your attendings that you are competent by your demeanor, display of obvious interest, and high level of preparation for each case evidenced by your ability to answer their questions/understand why you got a question wrong. If you do get a question wrong, do not fret. ENT is a subspecialty surgery, and you haven't even learned general surgical etiquette yet. You will go far by reviewing the pertinent anatomy and the purpose of the surgery.

Neurosurgery (West Jeff)

Neurosurgery will send orientation material and items specific to neurosurgery.

- Contact Jennifer Bordelon via email jbord7@lsuhsc.edu, prior to your Neurosurgery rotation

Pediatric Service

Learning Objectives

Upon completion of this rotation, the medical student is expected to be able to:

1. Describe the embryology, normal development, common congenital anomalies, and presentations of pediatric surgical conditions.
2. Describe the normal physiology of children of different ages.
3. Evaluate pediatric patients and begin treatment of those with surgical conditions, trauma victims, and critically ill patients. Also, be able to recognize when a presenting patient does not have surgical condition, and institute an appropriate treatment plan or appropriate consultation.
4. Develop and refine surgical techniques so as to be able to perform all but complex "index cases" as primary surgeon with attending assistance. All residents performing a surgical procedure are expected to review the case ahead of time, read about the relevant physiology, pathophysiology, and technical conduct of the operation.
5. Interact effectively with members of the Pediatrics teams and sub specialists in the care of children.
6. Demonstrate professional behavior in carrying out all activities responsibly, adhering to ethical principles, and remaining sensitive and respectful of all patients and colleagues.

Responsibilities

Weekday table round begins ~7AM. Get to hospital early enough to update the google drive list of patients and to pre-round on patients you scrubbed in on. If you scrubbed in on the surgery, this is YOUR patient.

Updating the google drive list of patients: keep this as concise as possible and more importantly, updated at all times! Make sure to update diet, weight, new surgeries, etc. The attendings *will* notice if the list is not

updated.

List Legend:

- **Grayed-out patient**: Consult that's on our radar but not our primary patient. Essentially, there's going to be a surgery on this patient at some point, but not right now. Do not have to round on this patient every day. However, make sure everything on patient is still up to date.
- **"-c"** next to attendings initial: patient was a consult
- **DOA**: date of arrival/admit into hospital
- **DOS**: date of surgery/surgeries
- **HPI**: include only pertinent/major history as well as any procedures done (e.g. s/p g-tube placement)
- **Abx/Drips/Ppx**: include most drugs with the exception of like what type of IV solution they're on, vitamins, etc.
- **Diet**: very important to keep updated. Informs us how the patient is progressing
- **Lines/tubes**: search "LDA" in epic to get this info. Include all except IVs
- **Notes/To-Dos**: List future surgery date, anything that needs to be done (dressing changes, orders, consents, etc.), and all follow up stuff like cultures, labs, imaging. This is a good opportunity to help the team by writing down what needs to be done. *Pay attention anytime anyone speaks!*
- **"G" or "Y"** next to the patient's name refers to which surgery attending is mainly following this patient (Gray or Yu)

Pre-Op:

Outpatient pre-op on 2nd floor: Residents will be running up here before surgery to get consent forms signed

Inpatient pre-op on 1st floor PACU: All patients will usually wind up in PACU before/after surgery. Sometimes patients from the ICU will roll directly back to the OR without going to PACU, so make sure you're keeping an eye out for these patients and not missing anything!

You should have: Lidocaine, bacitracin, umbilical cath kit, gomco clamp (may need multiple sizes), extra scalpel, tuberculin needle, sweeties (essentially sugar water), gowns, and sterile gloves (one for resident and one for attending)

Helpful hints:

- Read up on patients, disease process, and the surgery itself beforehand. Don't go into this rotation super-gunnery. Feel out the different personalities.
- First things you need to do when walking into the OR is write the residents name and your name on the marker board. Ensure enough gowns/gloves are pulled for everyone including yourself.
- Help the staff get the patient set up for surgery, whether that means wiping off poop or strapping the patient in. Help the staff after the surgery by bringing in the bed, grabbing warm blankets, cleaning up the OR, moving patient from table to bed, etc.
- Be prepared to be pooped or peed on. Stuff happens. Roll with it.
- You can ask questions during surgery, but don't do it at inappropriate times. Have scissors ready to cut sutures.
- Ask the residents what you can do to help them out. Sometimes they'll tell you to just go to the

library and study, but occasionally check in to see if there's anything they need.

- Make sure to text the residents when patients are rolling back to the OR! This is probably one of your most important roles on the peds surgery team.
- Call is 2 weekend days. Rounds begin at ~9ish, but that is subject to attending's whims and/or emergency traumas. Confirm with resident. As per usual, show up with enough time to get your work done.
- Helpful resources
    - SAGES (society of GI and endoscopic surgeons)
    - NMS surgery textbook's section of Pediatric Surgery
    - Online Med Ed — Peds surgery section

Plastics Service

Plastics Service will send students a rotation manual specific to Plastics.

Trauma Intensive Care Unit (TICU)

Learning Objectives

Upon completion of this rotation, all medical students should be able to:

1. Perform a focused history and examination in a critically ill surgical patient.
2. Develop a priorities list and plan of care for all critically ill patients
3. Recognize significant changes in patient status.

Clinic:

Bring a laptop with EPIC access. There are only 2 computers for Dr. Yu/Gray and their assistant. It helps a lot being able to access patient charts to read their history. Try to keep the history/exam very brief.
Clinic runs quickly.

1. Achieve a knowledge base in basic science and clinical management appropriate to their level of training. This will include knowledge of:
    a. Pathophysiology of injury and the immune response to infection
    b. Diagnostic workup of a patient with signs of shock
    c. Initial evaluation and treatment of shock
2. Be able to develop appropriate diagnostic and treatment algorithms for common ICU emergencies.
3. Present a system-based summary of TICU patients for whom they had the primary responsibility.
4. Discuss the pathophysiology and associated medical problems of respiratory insufficiency.
5. Understand indications for intubation and mechanical ventilation.
6. Develop an understanding of the importance of the multidisciplinary approach to patients in the TICU.

Responsibilities

Medical students should participate in all patient care activities. These include:

1. Providing all appropriate inpatient care for patients admitted to the service.
2. Performing appropriate preoperative preparation including submitting OR room request form ("booking sheet").
3. Being involved in the operative care of patients on the service when their on-call responsibilities do not preclude such participation. You should be completely prepared for every OR case prior to

scrubbing in. This means that you have reviewed the patient's history and know the results of all laboratory, radiology and pathology studies. In addition, you will be expected to read about the patient's disease process, the treatment options, and the details of the proposed surgery (including all relevant anatomy), and the surgical techniques involved.

4. Seeing the same patient daily, examining every patient including wounds, reviewing appropriate laboratory and study data results.
5. Following up results of imaging, cultures, specialized labs, studies, and procedures and reporting these to the team in a timely fashion.

Urology Service

Learning Objectives

The urology rotation involves adult and pediatric patients in the following settings:

1. UMC Clinic and Hospital Service-Active participation of patient care in both settings with supervision by residents and faculty.
2. Touro Infirmary and East Jefferson Service- Active participation in private care facility staffed by LSU residents and faculty.

All students will participate in weekly preoperative conferences in which cases for the upcoming week are reviewed.

Didactic conferences -Yenni Cancer Center; Corner of Hudson and Ithaca. Type in coordinates (30.0119773, -90.1820405) in Apple/Google Maps for approximate location and driving directions -Go to conference room on 3rd floor (turn left out of the elevators) -Location of Thursday evening pre-op conference and didactics (3:30- 5:45PM)Additional review course sessions via Zoom are held one or two evenings per week. Residents will let students know specifics weekly.

By the end of rotation, students will be expected to be proficient in performing a complete GU history, physical exam, and placement of uncomplicated Foley catheters in both sexes. Students should also be able to formulate a differential diagnosis and plan. Guidelines of common GU pathology and appropriate management are available online and in a handbook loaned during the rotation. Students will cover high yield content in Urology in preparation for student board examination.

Vascular Surgery (updated Sept. 2022)

Learning Objectives

Upon completion of this rotation, all medical students are expected to be able to:

1. Develop a comprehensive plan for the care of the common vascular diseases.
2. Understand the pathophysiology of:
    a. Peripheral artery disease
    b. Aortic aneurysmal disease
    c. Carotid artery disease
    d. Venous insufficiency
    e. And understand the algorithm of vascular access for hemodialysis
3. Understand the work-up of each major vascular disease process (2.a.-e.)

4. Understand treatment options for patients with various stages of vascular disease.

5. Develop an understanding of the importance of the multidisciplinary approach for work-up and pre- operative clearance for carotid, peripheral arterial, and aortic artery operations.

6. Discuss the identification and classification of arterial stenosis based on imaging.

7. Perform a focused history and examination in a patient with symptoms of peripheral artery disease

   a. Classify claudication

   b. Interpret non-invasive and arterial Doppler reports

8. Recognize conditions that warrant immediate admission for work-up and possible urgent surgical or endovascular intervention.

All students rotating on the vascular surgery service should be able to:

1. Incorporate a thorough vascular and pulse exam into the history and physical exam.
2. Be familiar with the risk factors for atherosclerotic vascular disease.
3. Describe the diagnostic evaluation, including noninvasive vascular studies and imaging options for, and the indications for intervention for carotid stenosis, abdominal aortic aneurysm, aortic dissection and peripheral arterial occlusive disease.
4. Describe basic principles of operative and endovascular intervention for remedy of vascular surgical problems including carotid stenosis, AAA, aortic dissection and peripheral arterial occlusive disease.
5. Describe the basic pathophysiology and management of thoracic outlet syndrome and venous occlusive disease (including May-Thurner and Paget-Schroetter syndromes and deep venous thrombosis).

Responsibilities

1. Participate in the management of inpatient vascular surgery patients
2. Vascular Surgery Outpatient Clinic.
3. Vascular Conference.

Appendix 1: SOAP Notes and H&Ps

History and Physical

This is the note written the first time a patient is seen and should tell us anything we need to know about the patient. H&Ps are done for surgery cases to be booked and for consults in the ER or on the floor. Many times we will be consulted for a specific reason for a patient that is already admitted to another service in the hospital. i.e. Patient being treated for many med problems by the medicine service but has an abscess that may need to be "I&D"' (drained). In this situation our main attention is on what we are being consulted for. However; remember that you are a doctor first and be sure to know everything going on with the patient.

The SOAP Note

The "SOAP" note is the standard everyday note written on patients on the floor after their initial H&P. Although it is no longer exactly as it used to be with the new EMR, **this is the format to use in presenting your patients in the morning.**

S = Subjective

This includes events over the last 24h and the subjective complaints of the patient. i.e. passing gas? BM? Tolerating food? Nausea/emesis? Ambulating?

O = Objective

What you find on physical exam of the patient. List their vitals including Tmax (maximum temperature for last 24h); ins/outs with full detail for all drains present (foley, NG tube, ostomy, chest tube); and "full" physical exam. Be sure to include parts of the exam pertinent to your patient. i.e. HEENT exam if ENT pt., comment on wounds

A = Assessment

Summary of what is going on with the patient. All of the medical problems being addressed this hospital stay are listed here. Be sure to list post op day! (POD#x)

P = Plan

Your recommendations (or the team's recommendations) on what to do with the pt. today. i.e. advance diet, ambulate, replace potassium

Tubes and Drains

All drains – look at color of fluid in drain or canister; output should be recorded in the ins and out section of Epic; be sure the 24h total is in your note!

JP – Jackson-Pratt drain: a surgical drain – "grenade" attached to tube

CT – chest tube: attached to pleuravac – look for "air leak"

NG – nasogastric tube: out of nose to suction canister; used to decompress the stomach

Ostomy – colostomy, ileostomy; look at drainage, look for air in bag

Wound vac – sponge in wound to negative pressure; look for tight seal, look at pressure on machine – should be 125mm Hg

Suggested textbooks:

- **Cope's Early Diagnosis of the Acute Abdomen** ○ Cope's book will be checked out to students on a first-come-first-serve basis and must returned the Thursday before your General Surgery ends.
  - If not returned by the end of the General Surgery rotation, you will receive an INCOMPLETE.
  - Cope's is an extremely well-written book on the basics of an abdominal exam. It's like a private rotation with a master surgeon. It's essential reading for students interested in a career in surgery. You will not be quizzed, but if you read it, it will be obvious.
- **General Surgery Essentials by Peter Lawrence, 4th Ed.)**
  - A great reference for students, useful when studying for USMLE steps 1, 2 & 3

Other Recommendations:

- **NMS Case Files in General Surgery**
  - A student favorite, a good study guide
- **Surgical Recall**
  - Standard ammo in a student's pocket, good daily pocket review
  - Advanced Surgical Recall (written for junior surgical residents, or students gunning for a surgical career)
- **Pre-Test for General Surgery**

- By all accounts a difficult read, but if you expect to do very well on the shelf, you should be running at this speed

- **Kaplan Review for General Surgery**
  - Contains the famous Pestana review, a favorite for high-yield facts. A good review, not a great reference
- **Mont Reid Handbook**
  - A great pocket-reference with extensive content in bullet form if you like that sort of thing
- **The Washington University Handbook**
  - Like the Mont Reid but more paragraphs than bullets, if you prefer this sort of thing

Orders

Orders can be written by students and then are pended until the resident signs them. We encourage you to write orders as it is good practice for when you are the intern. After writing orders let your intern know they are there and ready to be signed.

Abbreviations

AC – before meals ("ante cebum")

ADA – American diabetic association

DP – Dorsalis pedis

BID – twice a day

BLE – bilateral lower extremity

CXR – chest x-ray

DP – dorsalis pedis

F/u – follow up

I&D – incision and drainage

OOB – out of

PO – by mouth

PR – per rectum

PRN – as needed

PT – posterior tibial

QD – daily

QHS – at bedtime ("quaque hora somni")

SCDs – sequential compression devices

TEDS – thromboembolic deterrent stockings

TID – three times

Appendix 2: Wound Care Notes

Wounds are a common aspect of care in all surgical specialty practice. However, there are a wide variety of different wounds based on the initial type, patient condition, and surgical goals. This is a broad overview of routine care of most types of commonly-found wounds

Post-Operative Incisions

These are generally clean, sharp-edged wounds with little or no surrounding tissue trauma. These can be stapled or sutured closed with internal (absorbable) or external (non-absorbable) sutures.

- Post-operative dressings should generally be removed POD#2 and left open to air **unless otherwise specified**. Slight serous drainage is common, new dry gauze can be left in place until it is completely dry.
- Staples and Non-absorbable sutures should be removed POD#7-14. The exception is fine cosmetic suture (on the face, e.g.) or occasionally neck incisions. These should be removed within 5 days.
- Copious serous or purulent drainage, redness, increasing tenderness are all signs of underlying infection and/or fascial dehiscence. The wound should be re-opened and left to heal by secondary intention under the supervision of the resident.

Infected Wounds

These are the result of a primary infection such as an abscess, infected ulcer, or secondary to postoperative wound infection

- Purulent drainage needs to be thoroughly evacuated several times per day.
- Sometimes a strip of gauze, drain, or other material is left in to promote external drainage.
- Dry gauze overlying the drain or open wound needs to be changed several times per day.
- A saturated dressing on a wound is a nice culture medium…a great way to prolong an infection.
- Warm, red, shiny, tender skin surrounding a wound is cellulitis, which warrants systemic antibiotics.

Complex Reconstructive Wounds

Sometimes wounds cannot be closed due to lack of epithelialized skin/tissue to cover the defect and/or because there is an underlying connection to intestinal, urologic, gynecologic structures that produce significant flow of fluid into the wound. These are called fistulas and make wound care a significant challenge for everyone, including the patient.

Negative Pressure Wound Therapy (NPWT) or Wound Vacuum Assisted Closure (Wound VAC) are devices used to assist in management of these wounds. These are typically placed first in the OR, then eventually at the bedside when it becomes less traumatic for the patient

- Dressings are changed every 2-4 days.
- Wound Care Nurses often perform these dressing changes. Assist them whenever possible to learn how and to keep an eye on the wound for them team.

Topical Solutions:

- Chlorhexidine prep is good against MRSA but is very cytotoxic. It should never be used inside a wound of any sort.
- Dakin's Solution: (1% or 2% Chlorine bleach in water) is a powerful antibacterial very good against pseudomonas. Any infected wound with blue-green discoloration in the gauze that smells like rotten fruit might benefit from this use. It is, however, also very cytotoxic. Not to be used in clean, healing wounds with good granulation tissue.
- Hydrogen Peroxide: Is a moderately strong antibacterial but also very cytotoxic. Only for use in frankly infected/contaminated abscess cavities. How cytotoxic is it? Try gargling with it.
- Silvedene Ointment: Is a Silver Sulfadiazene paste useful on 1st and 2nd degree burns or significant abrasion injuries. Antibacterial and cytoprotective but also very expensive. Do not use on patients with sulfa allergies.

Dressing Type

Dressing	Cytotoxic	Debriding	Use
Dry-to-Dry	No	Yes	Dry gauze for use on wounds that weep or ooze.
Iodoform Packing	Yes	No	Iodine -compound impregnated strips.
Plain Packing	No	No	Same as iodoform strip but without the iodine.
Calcium Alginate	No	No	Sold as Aquacel Ag or Restore Silver-impregnated or plain. This alginate product looks like felt but becomes jelly-like.
Xeroform Gauze	Yes	No	Petroleum & Iodide compound dressing.
Telfa	No	No	Non -adherent dry dressing keeps wound.
Adaptek	No	No	Non-adherent petroleum-soaked mesh. Allows fluid to pull through into the vacuum dressing without suctioning a hole in the bowel

Appendix 3: Site Contacts

BATON ROUGE	**Site Contact General Surgery/ Surgery Subspecialty**	**Contact Information**
	Shellee Harvey	Sharv3@lsuhsc.edu

		Program Coordinator / Contact	
Lafayette	**General Surgery**	Elissa Peters epete7@lsuhsc.edu	Kristi Anderson laf-medicaleducation@lsuhsc.edu (337)261-6156
	Subspecialty	Elissa Peters epete7@lsuhsc.edu	Kristi Anderson laf-medicaleducation@lsuhsc.edu (337)261-6156
	Charles Chappuis, MD		surgcwc@lsuhsc.edu (337)261-6179

TICU-UMCNO Contact Information

Trauma Fellows	**Contact Information**
Caitlyn McCall	(219)781-6265
Blake Platt	(913) 207-0312

Appendix 4: College Policies

Campus SaVE Act / Title IX - Disability Services – Equal Opportunity

The college's Title IX policy can be found at: https://www.lsuhsc.edu/titleix/

The Office of Disability Services can be found at: https://www.lsuhsc.edu/administration/academic/ods/

LSUHSC New Orleans Title IX Coordinator
Director of Disability Services
Leigh Smith-Vaniz (she/her/hers)
(504) 568-2211
titleix@lsuhsc.edu
Resource Center Building
433 Bolivar Street, Ste. 826A
New Orleans, LA 70112

LSUHSC New Orleans Campus Police
(504) 568-8999
Individuals are also strongly encouraged to report the offense to campus police or local law enforcement if they believe criminal conduct occurred (i.e. sexual assault, sexual battery, stalking, etc.). To the extent possible, the Complainant and those who receive the complaint should preserve evidence and not disturb a potential crime scene. (This includes preserving all text or email communications that may be related to the incident.

Confidential Advisors
Campus designees selected by Title IX Campus Coordinators and trained in accordance with Louisiana law to provide confidential services to students regarding reporting, supportive measures, rights to report to law enforcement and other information under this policy.

Other policies of interest to students may be found at:
https://www.lsuhsc.edu/administration/academic/policies.aspx

Equal Opportunity Policy can be found at: https://www.lsuhsc.edu/administration/hrm/relations-eeo.aspx